EXHIBIT

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Dr. Stieve testimony,

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disorders of those joints and so we call those comfort measures and we take the stance that prisoners are not allowed to have those on our dime while they're in prison.

Q. You talked about evidence-based standards or studies. Explain that to the Jury?

A Evidence-based standards, you know years ago women used to receive hormone replacement therapy and that's because a group of gynecologists -- I'll use a g-y-n example, but I could use any number of examples -- because they felt that that was important for women's heart health and general well-being after they went through menopause. Subsequent studies have shown that actually it's very deleterious to a woman to take estrogen supplements because of the increased risk of cardiovascular disease and breast cancer and so evidence-based studies help to direct the general practicing physician and to understanding that that's not something that we should be giving to our patients, that it could have harm instead of doing good.

Q. Would it be true -- let me ask you this. Relative to the care and treatment that Mr. Kensu was receiving with the MDOC during your time as CMO and maybe that brief time where you were Regional Director, would you use evidence-based medicine as part of your decision-making processes as to whether or not Mr. Kensu or any other inmate would get treatment?

A. Counselor, may I explain the hierarchy of how prisoners are cared for which I think will help the Jury to understand?

Q. Sure.

A. So the Michigan Department of Corrections only employs right now I believe two physicians. What they do with certain needs that the Department of Corrections

has such as food services is they get a vendor to supply all the meals to the employees and in the case of health care, when I came on board, CMS was the vendor for health care and so they provided the doctors, MDs and DOs, nurse practitioners and physician assistants that actually provided care for the prisoners. The nurses for the most part as far as I understand in the MDOC are State employees, so they're MDOC employees. But given that there were only I think at the most four doctors employed by the MDOC when I was part of the MDOC, and when I came there were over 50,000 inmates, it certainly wasn't practical in my role as either Regional Director nor as Chief Medical Officer to micro-manage the care of 50,000 inmates. We simply didn't have the time or the resources. In lieu of that, we hired vendors that had competent providers to see and evaluate those inmates and we set up protocols so that if those providers felt that the inmates needed specific care, that they could request that care from the administration and we needed to have some control over what care was given because again, most providers don't go to medical school and say when I graduate from medical school I think I want to work in a correctional facility as a physician. A lot of these physicians are foreign, as Mr. Kensu said. A lot of these providers have had other careers and are taking this up for various reasons. So as a Regional Medical Director, usually I would just -- or a Chief Medical Officer, usually I would just see problematic cases where the providers had an inkling that perhaps a special diagnostic study such as an MRI, a special laboratory test, a special medication might be needed. Now on numerous occasions I had occasion to address the providers from our vendor. We were very close. We tried to work together, and I would tell them that since I don't have boots on the ground in your facility, I'm not laying hands on the patients and examining them, that I expect you to argue and to be a patient advocate if the information you give me for a